

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS7520AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/16/2012
NAME OF PROVIDER OR SUPPLIER TRUE LOVING CARE II LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8020 FAIRFIELD AVE LAS VEGAS, NV 89123		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 000	<p>Initial Comments</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>This Statement of Deficiencies was generated as a result of an initial State licensure survey conducted in your facility on 11/16/12. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is requesting licensure for eight Residential Facility for Groups beds for elderly and disabled persons and/or persons with Chronic Illness, six Category I beds and two Category II beds.</p> <p>Deficiencies found were corrected during time of survey. Please keep a copy of the statement for your records. No further action is required.</p>	Y 000			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE